



Patient label

**PEDIATRIC EMERGENCY
NURSING ASSESSMENT - TREATMENT RECORD**

CTAS Level

Location in Department

Name/pronoun used:

Triage			
ARRIVAL STATUS TO ED: Date: _____ Time: _____		Accompanied by: <input type="checkbox"/> Self <input type="checkbox"/> Family/caregiver <input type="checkbox"/> Legal guardian	
<input type="checkbox"/> Walked in <input type="checkbox"/> Ambulance <input type="checkbox"/> Police <input type="checkbox"/> Section 28		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other: _____		Transferred from: <input type="checkbox"/> Scene <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____	
WEIGHT: _____ kg <input type="checkbox"/> Actual <input type="checkbox"/> Estimated with Broselow™	HEIGHT: _____ cm <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	AGE: _____	
PATIENT'S PRESENTING/CEDIS COMPLAINT:			
PEDIATRIC ASSESSMENT TRIANGLE		Work of Breathing: <input type="checkbox"/> Normal <input type="checkbox"/> Concerns identified	
Appearance: <input type="checkbox"/> Looks well <input type="checkbox"/> Looks unwell		Disability: <input type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Pain/Pressure <input type="checkbox"/> Unresponsive	
Circulation: <input type="checkbox"/> Normal <input type="checkbox"/> Concerns identified		Comments: _____	
Infection Control Screen Does the patient have symptoms suggestive of an infectious process? <input type="checkbox"/> No <input type="checkbox"/> Yes Precautions initiated: _____		Violence Screen <input type="checkbox"/> N/A <input type="checkbox"/> History of violence <input type="checkbox"/> Physically aggressive <input type="checkbox"/> Verbally aggressive Safety measures implemented: _____	
HISTORY PERTINENT TO PRESENTING/CEDIS COMPLAINT:			
VITAL SIGNS:	Glucose POCT:	mmol/L	Pain score:
Pain Scoring Tool:	Resp:	O₂ Sat:	% Supplemental O₂:
HR:	BP:	Temp:	PEWS score:
SEPSIS SCREENING: <input type="checkbox"/> Screen Negative <input type="checkbox"/> Screen Positive Escalation: _____			
SUICIDE SCREEN: <input type="checkbox"/> Risk Identified Comment: _____			
PAST MEDICAL HISTORY: <input type="checkbox"/> Previously healthy (If less than 6 months: Birth weight _____ kg Born at _____ weeks gestation)			
ALLERGIES: <input type="checkbox"/> NKDA <input type="checkbox"/> ADR <input type="checkbox"/> Allergies <input type="checkbox"/> Allergy band applied			
MEDICATIONS: <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> PharmaNet			
List all medications including over-the-counter, vitamins, inhalers, herbal, and any medications that the child may have accessed			Last Dose
			Last Time
IMMUNIZATIONS: <input type="checkbox"/> Up-to-date <input type="checkbox"/> Incomplete <input type="checkbox"/> Not given <input type="checkbox"/> Unknown Comment: _____			
LAST MEAL: <input type="checkbox"/> Last liquid: _____ h <input type="checkbox"/> Last solid: _____ h <input type="checkbox"/> NPO			
INTERVENTIONS: <input type="checkbox"/> C-Spine/Hard collar <input type="checkbox"/> Dressing/Sling/Splint <input type="checkbox"/> Nurse initiated activities: _____ <input type="checkbox"/> Other: _____			
FALLS: <input type="checkbox"/> Universal falls precautions considered and initiated		TRIAGE RN SIGNATURE:	
Waiting Area Reassessment			
Reassess Time	Patient Location	Progress Notes	Initials

Location in Department

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Date: _____ Time: _____

Initial Focused Assessment

A&B	Airway: <input type="checkbox"/> Clear <input type="checkbox"/> Maintains own <input type="checkbox"/> Other: _____	Respirations: <input type="checkbox"/> Even/Unlaboured <input type="checkbox"/> Other: _____	Air Entry: <input type="checkbox"/> Clear to bases bilaterally <input type="checkbox"/> Adventitious sounds: _____ <input type="checkbox"/> Cough	<input type="checkbox"/> O ₂ : _____ L/min <input type="checkbox"/> NP <input type="checkbox"/> Face mask <input type="checkbox"/> RT called <input type="checkbox"/> Other: _____
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C	Pulse (location): _____ <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Bounding	Capillary Refill: <input type="checkbox"/> Central _____ secs <input type="checkbox"/> Peripheral _____ secs	Skin Temperature: <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic	Skin Colour: <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundice
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D	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive <input type="checkbox"/> Behaviour normal for child	<input type="checkbox"/> Glucose POCT: ____ <input type="checkbox"/> Time: _____
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If any concerns identified in A, B, C or D, use P-ENAR documentation. Communicate, escalate and document as per BC PEWS Escalation Aid.

ENT <input type="checkbox"/> N/A	<input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Throat <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pain <input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Foreign Body	Comments: _____
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GI <input type="checkbox"/> N/A	<input type="checkbox"/> Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Breast fed <input type="checkbox"/> Bowel Sounds <input type="checkbox"/> Vomiting Last BM: _____ <input type="checkbox"/> Formula	Comments: _____
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GU <input type="checkbox"/> N/A	<input type="checkbox"/> Dysuria <input type="checkbox"/> Hematuria <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency	Number of diapers/voids 24 hours: _____ Last void: _____	<input type="checkbox"/> Penile pain <input type="checkbox"/> Penile discharge <input type="checkbox"/> Scrotal pain	<input type="checkbox"/> Urine POCT <input type="checkbox"/> Negative <input type="checkbox"/> Positive: _____
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Reproduction <input type="checkbox"/> N/A	<input type="checkbox"/> Pain <input type="checkbox"/> Bleeding/Discharge <input type="checkbox"/> Pregnant: _____ weeks LMP: _____ Gravida: _____ Para: _____ Abortus: _____	<input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Negative <input type="checkbox"/> Positive
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MSK <input type="checkbox"/> N/A		<input type="checkbox"/> Dressings applied <input type="checkbox"/> Splint: _____																																																				
		<table border="0"> <tr> <td>#</td> <td>Fracture</td> <td>D</td> <td>Deformity</td> <td>POI</td> <td>Pattern</td> </tr> <tr> <td>#C</td> <td>Compound</td> <td>E</td> <td>Edema</td> <td></td> <td>of injury</td> </tr> <tr> <td></td> <td>Fracture</td> <td>Er</td> <td>Erythema</td> <td>Pu</td> <td>Purpura</td> </tr> <tr> <td>A</td> <td>Abrasion</td> <td>H</td> <td>Hematoma</td> <td>R</td> <td>Rash</td> </tr> <tr> <td>AM</td> <td>Amputation</td> <td>L</td> <td>Laceration</td> <td>S</td> <td>Swelling</td> </tr> <tr> <td>B</td> <td>Burn</td> <td>P</td> <td>Pain</td> <td>T</td> <td>Traction</td> </tr> <tr> <td>Bi</td> <td>Bite</td> <td>Pet</td> <td>Petechiae</td> <td>///</td> <td>Crush</td> </tr> <tr> <td>Bl</td> <td>Bleeding</td> <td>PI</td> <td>Penetrating</td> <td>+</td> <td>Bruising</td> </tr> <tr> <td>C</td> <td>Contusion</td> <td></td> <td>Injury</td> <td></td> <td></td> </tr> </table>	#	Fracture	D	Deformity	POI	Pattern	#C	Compound	E	Edema		of injury		Fracture	Er	Erythema	Pu	Purpura	A	Abrasion	H	Hematoma	R	Rash	AM	Amputation	L	Laceration	S	Swelling	B	Burn	P	Pain	T	Traction	Bi	Bite	Pet	Petechiae	///	Crush	Bl	Bleeding	PI	Penetrating	+	Bruising	C	Contusion		Injury
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Comments: _____

Concerns for non-accidental trauma (refer to guide for use); MRP made aware As per Duty to Report Legislation call made to MCFD 1-800-663-9122

Neuro-vascular <input type="checkbox"/> N/A	Location:				Pulse Strength	Right:	Left:
	Colour	Warmth	Movement	Sensation	Pulse Location		
	<input type="checkbox"/> Normal <input type="checkbox"/> Mottled <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic	<input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Impaired	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Diminished	<input type="checkbox"/> Radial <input type="checkbox"/> Brachial <input type="checkbox"/> Femoral <input type="checkbox"/> Dorsalis Pedis <input type="checkbox"/> Posterior Tibial	0 = Absent 1+ = Diminished/Weak 2+ = Expected/Moderate 3+ = Full/Increasing 4+ = Bounding/Strong D = Doppler	



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Mental Health & Substance Use	Interventions <input type="checkbox"/> None
<input type="checkbox"/> Section 28 with police <input type="checkbox"/> Form 21 Status: <input type="checkbox"/> Appropriate <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Angry/Irritable <input type="checkbox"/> Paranoid/Suspicious <input type="checkbox"/> Agitated/Impulsive <input type="checkbox"/> Withdrawn Nicotine Use: <input type="checkbox"/> N/A Alcohol Use: <input type="checkbox"/> N/A Substance Use: <input type="checkbox"/> N/A Type: _____ Type: _____ Type: _____ Route: _____ How much: _____ Route: _____ How much: _____ How often: _____ How much: _____ How often: _____ Last time used: _____ How often: _____ Last time used: _____ Last time used: _____ Risks Identified: <input type="checkbox"/> None <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Homicidal ideation <input type="checkbox"/> Flight risk <input type="checkbox"/> Self harm <input type="checkbox"/> Self-deterioration <input type="checkbox"/> Substance Withdrawal <input type="checkbox"/> Stated plan for harm: _____ Comments: _____	<input type="checkbox"/> Certified/Admitted involuntarily via the Mental Health Act Contact: <input type="checkbox"/> Patient aware <input type="checkbox"/> Indigenous Patient Liaison <input type="checkbox"/> Social Worker <input type="checkbox"/> Mental Health Team <input type="checkbox"/> Substance Use Team <input type="checkbox"/> Concurrent Disorders Team <input type="checkbox"/> Other: _____ <input type="checkbox"/> Validated screening tool(s) used based on risks identified: _____ <input type="checkbox"/> Violence and Aggression ALERT completed <input type="checkbox"/> Safety/Risk Mitigation Plan initiated

Fluid Balance (volume documented in mL)

Intake								Output		
Time	Site	Catheter Size	Initials	Solution/Blood	IV Amount Start	IV Amount Infused	Oral Intake	Time	Type	Amount
Total								Total		

Time	Medication	Dose	Route	Initials	IDC

ABBREVIATIONS

A	Airway	ENT	Ear, Nose and Throat	Lpm	Litre per minute	NPO	Nothing Per Mouth
ADR	Adverse Drug Reaction	GI	Gastrointestinal	MCFD	Ministry of Children and Family Development	O ₂ Sat	Oxygen Saturation
B	Breathing	GU	Genitourinary	mL	Milliliter	PEWS	Pediatric Early Warning System
BP	Blood Pressure	h	Hour	mm	Millimetre	POCT	Point Of Care Testing
C	Circulation	HR	Heart Rate	mmo/L	Millimole per litre	R	Right
CEDIS	Canadian Emergency Department Information System	IDC	Independent Double Check	MRP	Most Responsible Practitioner	Resp	Respiration
cm	Centimeter	kg	Kilogram	MSK	Musculoskeletal	RN	Registered Nurse
CTAS	Canadian Triage and Acuity Scale	L	Left	N/A	Not Applicable	RT	Respiratory Therapist
D	Disability	LBM	Last Bowel Movement	NP	Nasal Prongs	Temp	Temperature
ED	Emergency Department	LMP	Last Menstrual Period	NKDA	No Known Drug Allergies		

